CalWORKs and WELFARE TO WORK TIME LIMIT EXEMPTION DETERMINATION

COUNTY	
CASE NAME	
CASE NO.	OTHER ID NO.
WORKER NAME	

Questions? Ask your worker.

Date_____

On _____ (DATE), _____ (NAME) requested an exemption, and the county made the following determination:

A. WELFARE TO WORK PARTICIPATION (WTW) EXEMPTIONS

1. ☐ The exemption is APPROVED.

   He/she will not be required to participate in Welfare to Work. His/her exemption will end on _____ (DATE). If his/her exemption should continue, he/she must provide information to show that it should continue, before the ending date above, or he/she will be expected to participate in Welfare to Work.

   He/she can ask to volunteer to participate in Welfare to Work and will be told what activities and/or services are available.

   Reason for exemption from Welfare to Work participation:_____

   _____

   His/her condition may be looked at again to see if he/she continues to be exempt. If he/she is no longer exempt, he/she will be expected to participate in Welfare to Work.

2. ☐ The exemption is DENIED.

   He/she is required to participate in Welfare to Work. He/she will get a notice from the county telling him/her when to attend the Welfare to Work activities and/or services.

   Reason for Denial:_____

   _____

B. CalWORKs 60-MONTH TIME LIMIT EXEMPTIONS

1. ☐ The exemption is APPROVED.

   Each month of aid for the period that his/her condition or circumstance lasts will not count toward the CalWORKs 60-month time limit. His/her exemption will end on _____ (DATE). If his/her exemption should continue, he/she must provide information to show that it should continue, before the ending date above, or he/she will be expected to participate in Welfare to Work.

   Reason for exemption:_____

   _____

   His/her condition may be looked at again to see if he/she continues to be exempt. If he/she is no longer exempt, each month of aid will count toward the 60-month time limit.

2. ☐ The exemption is DENIED.

   Each month of aid will continue to count toward the CalWORKs 60-month time limit.

   Reason for Denial:_____

   _____

CONTACT YOUR WORKER IF YOU THINK THIS NOTICE IS WRONG. YOU MAY ALSO ASK FOR A STATE HEARING. "YOUR HEARING RIGHTS" FORM ON THE BACK SIDE OF THIS PAGE TELLS YOU HOW TO ASK FOR A STATE HEARING.

Rules: These rules apply; you may review them at your welfare office: MPP 42-302.1, 42- 302.2, 42-302.21, 42-302.3 - .34, 42-710, and 42-712.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE